

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02847

02820

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Crisfield</b> c. LENGTH OF STAY IN 1b <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Crisfield</b> d. STREET ADDRESS <b>Rt. 1, Box 214</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELBERT BRITTINGHAM</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 10, 1889</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph E. Brittingham</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Stephen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 1918 - 1919</b>		16. SOCIAL SECURITY NO. <b>218-20-6562</b>	
17. INFORMANT <b>Leon Hall</b>		Address <b>Crisfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>5271</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Emphysema, chronic</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>  <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour m.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>C. G. Rawley</b> EXAMINER'S NAME (Type) <b>C. G. Rawley, M. D.</b>		22. DATE SIGNED <b>Feb. 8, 1966</b> Address (Street, city, town, or county) <b>Crisfield, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 9, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Crisfield Som., Md.</b>	
24. FUNERAL DIRECTOR <b>Anthony E. Ward</b>		ADDRESS <b>Crisfield, Md.</b>	
25a. REC'D BY REGISTRAR <b>FEB 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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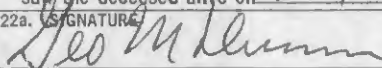
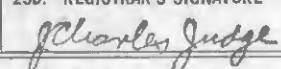
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02848

02821

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Somerset</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> c. LENGTH OF STAY IN ID <b>37 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Willie</b> Middle <b>Charles</b> Last <b>Charles</b>		<b>4. DATE OF DEATH</b> Month <b>2</b> Day <b>15</b> Year <b>1966</b>					
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6/1/04</b>	<b>9. AGE</b> (In years last birthday) <b>61</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Labor</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Work For City</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>North Carolina</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>		
<b>13. FATHER'S NAME</b> <b>Willie Charles Sr</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Tea Boomer, Princess Anne, Maryland</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMY FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Tea Boomer, Princess Anne, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> 4201 DUE TO <b>ATHEROSCLEROTIC C.V.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>10 MIN</b> <b>7 YEARS</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>PROBABLE LAENNEC'S CIRRHOSIS</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)				
<b>21. I certify that (I) (this hospital) attended the deceased from 10 AM 2-14, 1966, to 2:35 AM 2-15, 1966, that (I) (we) last saw the deceased alive on 2-14, 1966, and that death occurred at 2:35 AM, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> 				<b>22b. DATE SIGNED</b> <b>2-18-66</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Geo. M. Dunn, M.D.</b>				<b>22d. ADDRESS</b> <b>PRINCESS ANNE, MD.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>1/19/66</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt Carmel</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Princess Anne, Maryland</b>				
<b>24. FUNERAL DIRECTOR</b> <b>William H. James Jr. Princess Anne, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>Feb 21 1966</b>	<b>25b. REGISTRAR'S SIGNATURE</b> 				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>CERTIFICATE OF DEATH</b>											
1. PLACE OF DEATH a. COUNTY		Somerset				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b			
		MARYLAND				Crisfield		24 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		McCreedy Memorial Hospital				d. STREET ADDRESS		S. Somerset Avenue			
3. NAME OF DECEASED (Type or print)		First William		Middle F		Last Green		4. DATE OF DEATH		Feb. 5 1966	
5. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		WIDOWED		DIVORCED		Dec. 8, 1909		56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Plating		Cutlery		Somerset Co., Md.		U.S.		Months Days		Hours Min.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Fletcher Green				Beulah Watson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
no				Mrs. Lucille Green: Crisfield, Md.		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1530 Carcinoma of Cecum		2 yrs.			
						DUE TO					
						DUE TO					
						DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 1/7, 1964 to 2/5, 1966, that (I) (we) last saw the deceased alive on Feb. 5, 1966, and that death occurred at 8:30M, from the causes and on the date stated above.											
22a. SIGNATURE R. E. Roberts								22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) R. E. Roberts, M.D.								22d. ADDRESS		Crisfield, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)	
Burial				2/8/1966		Asbury		Crisfield, Md.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
James Hunnan				Crisfield, Md.				FEB 14 1966		Charles Judge	

1880

STATE OF NEW YORK

1880

IN SENATE

January 10, 1880

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

AT ITS SESSION ON JANUARY 10, 1879

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ALBANY:

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W. H. BARNES, PRINTER.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 02850 CERTIFICATE OF DEATH 02823									
1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Accomack</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>			c. LENGTH OF STAY IN 1b <b>2 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tangier</b> <b>93-3</b>				d. STREET ADDRESS <b>- - -</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCready Memorial Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>L.</b> Last <b>Haynie</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>14</b> Year <b>1966</b>						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1903</b>		9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Crab &amp; Oyster</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Tangier, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Robert W. Haynie</b>					14. MOTHER'S MAIDEN NAME <b>Maggie Lee Sparrow</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Emma P. Haynie, Same as 2. abc</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage -</b> <b>260X</b> DUE TO (b) <b>Gen'l arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Diabetes mellitus</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 days -</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetic Acidosis</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>12-12, 1966</b> , to <b>12-14, 1966</b> , that (I) (we) last saw the deceased alive on <b>12/14/66</b> 19, and that death occurred at <b>3A</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>C. G. Rawley</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/14/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. C. G. Rawley, M.D.</b>					22d. ADDRESS <b>Crisfield, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 17, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Swain Memorial Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Tangier, Virginia</b>			
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>					25a. REC'D BY REGISTRAR <b>FEB 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02851

02824

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HOPEWELL</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEAL ISLAND</b>		19-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>JOHNSON NURSING HOME</b>				d. STREET ADDRESS <b>MAIN ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SADIE</b> Middle <b>JONES</b> Last <b>JONES</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>13</b> Year <b>1966</b>			
5. SEX <b>7</b>	6. COLOR OR RACE <b>COL.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 31-1900</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired—</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seaford worker</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIE T. JONES</b>			14. MOTHER'S MAIDEN NAME <b>BLANCHE HUGHES</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>SAMUEL JONES</b> Address <b>Box 66</b> <b>MARION STATION—MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>381X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gen'l arterio-sclerosis</b> DUE TO (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days—</b> <b>4 yrs—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 2, 1965</b> , to <b>Feb. 13, 1966</b> , that I last saw the deceased alive on <b>Feb. 13, 1966</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED <b>2/15/66</b>							
ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D.				PHYSICIAN'S NAME (Type) <b>C. G. Rawley, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-16-66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>JOHN WESLEY CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>Deal Island Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. S. Webster</b> ADDRESS <b>Princess Anne</b>				24a. REC'D BY REGISTRAR <b>FEB 21 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1907

Wm. J. Sullivan  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

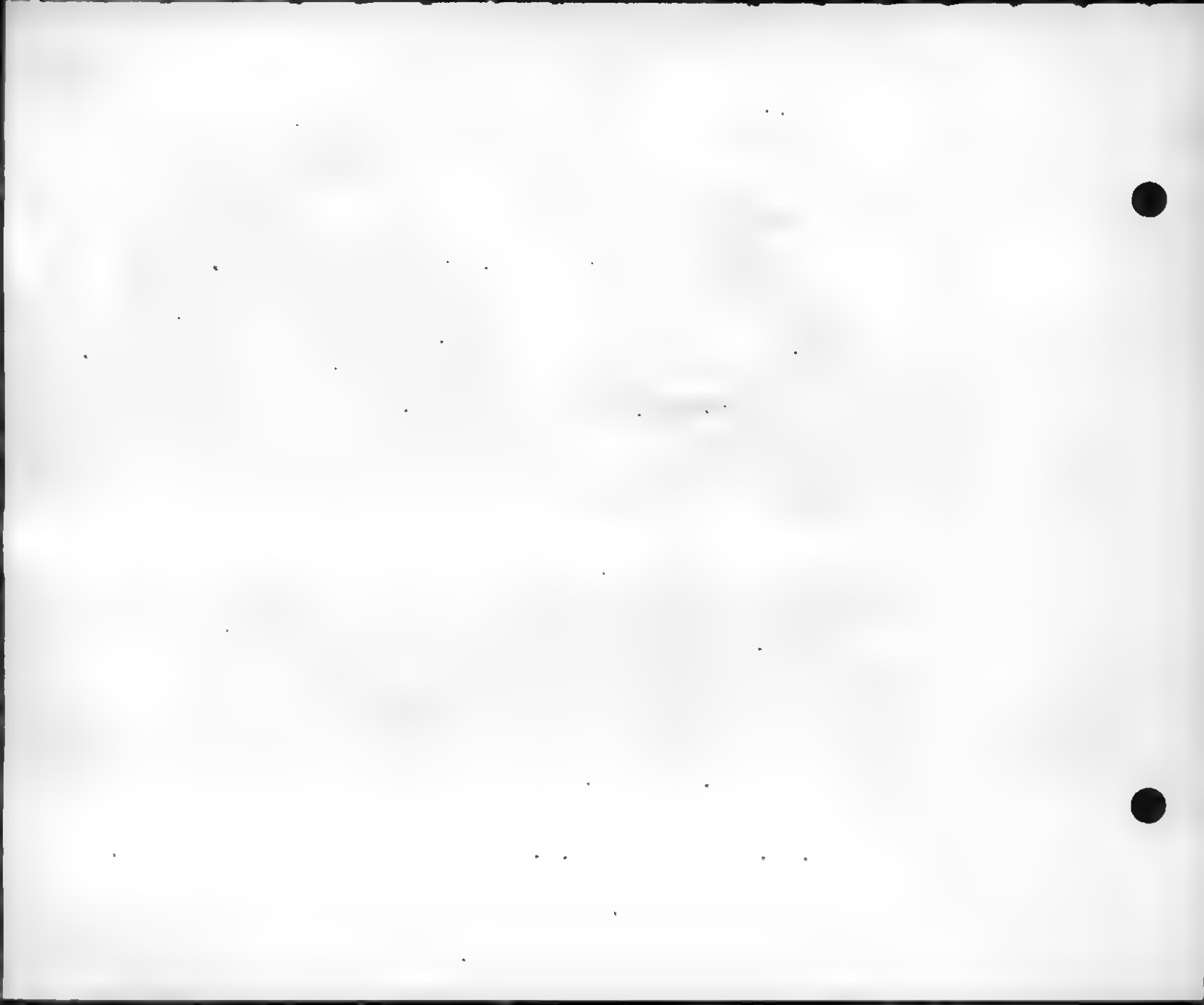
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02852

02826

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>McCready Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Marion</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mollie M. Parker</b> First Middle Last		4. DATE OF DEATH <b>Feb. 24 1966</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 2-1893</b> yrs. 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Phil., Pa.</b>
13. FATHER'S NAME <b>ISSAC DASHIELD</b>		14. MOTHER'S MAIDEN NAME <b>FANNIE TURPIN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Louise Lyon Phil., Pa.</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage R Hemisphere</b> DUE TO (b) <b>Hypertension</b> underlying cause last. (c) <b>General Arterio Sclerosis. Chronic myocardial disease of vessels.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of (item 18.) <b>no injury</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-18</b> , 1966, to <b>2-24</b> , 1966, that (I) (we) last saw the deceased alive on <b>Feb. 24</b> , 1966, and that death occurred at <b>4:30M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>G. C. Coulbourn</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>G. C. Coulbourn, M.D.</b>		22d. ADDRESS <b>Marion Crisfield, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Feb 27-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Branch</b>		23d. LOCATION (City, town or county) (State) <b>MARION CO. MD</b>	
24. FUNERAL DIRECTOR <b>Charles H. Ward</b>		25a. REC'D BY REGISTRAR <b>Mar 3 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



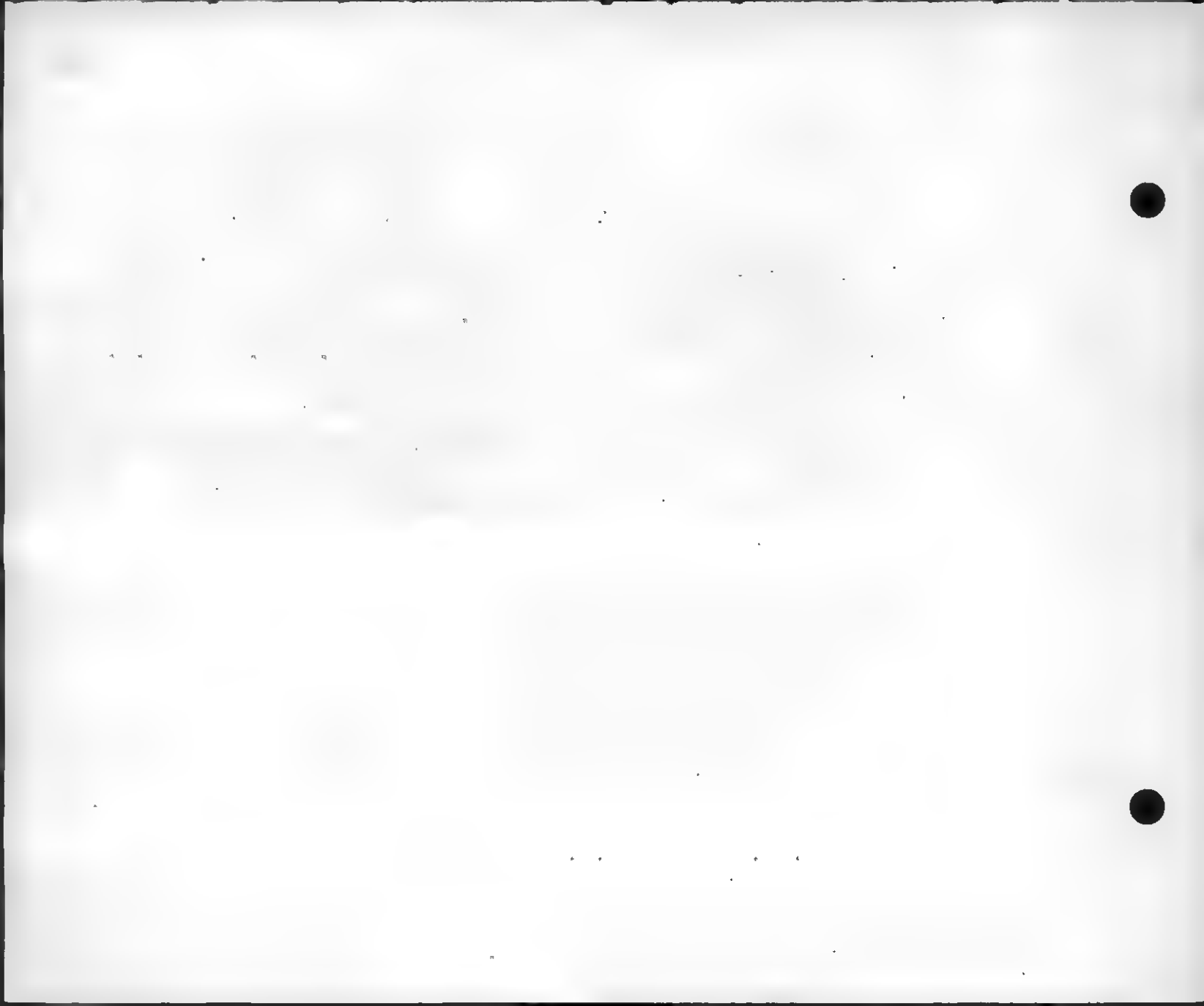
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Somerset</span> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Crisfield</span> c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">1 Day</span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <span style="font-size: 1.2em;">McCready Memorial Hospital</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Somerset</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Crisfield</span> <span style="float: right;">19-1</span> d. STREET ADDRESS <span style="font-size: 1.2em;">35d. &amp; Main St.</span> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">William Kirk</span> <span style="float: right;">First Middle Last</span> <span style="font-size: 1.2em;">Kirk</span> <span style="float: right;">Sterling</span>		<b>4. DATE OF DEATH</b> <span style="font-size: 1.2em;">2/3/66</span> <span style="float: right;">Month Day Year</span> <span style="font-size: 1.2em;">19</span>	
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span> <b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Dec. 7, 1898</span> <b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">67</span> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Merchant</span> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <span style="font-size: 1.2em;">Somerset Co., Md.</span> <b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">William Sterling</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Ella Sterling</span>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">no</span> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> <span style="font-size: 1.2em;">Harvey Sterling, Crisfield, Md.</span> <span style="float: right;">Address</span>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">4201</span> <span style="font-size: 1.2em;">Acute Myocardial Infarction</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">12 hrs.</span>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <span style="font-size: 1.2em;">19</span>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town) (County) (State)</b> _____	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">Nov.</span> , 19 <span style="font-size: 1.2em;">65</span> , to <span style="font-size: 1.2em;">Feb 3</span> , 19 <span style="font-size: 1.2em;">66</span> , that (I) <del>(we)</del> last saw the deceased alive on <span style="font-size: 1.2em;">2/3/66</span> 19____, and that death occurred at <span style="font-size: 1.2em;">2:40</span> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <span style="font-size: 1.2em;">A. G. Edwards</span>		<b>22b. DATE SIGNED</b> _____	
<b>22c. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">A. G. Edwards, M.D.</span>		<b>22d. ADDRESS</b> <span style="font-size: 1.2em;">Crisfield, Maryland</span>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>23b. DATE THEREOF</b> <span style="font-size: 1.2em;">2/5/1966</span>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Sunnyridge</span>		<b>23d. LOCATION</b> (City, town or county) (State) <span style="font-size: 1.2em;">Hopewell Md.</span>	
<b>24. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">James Hannon</span>		<b>25a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">FEB 6 1966</span>	
<b>25b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Crisfield, Md.</span>		<b>25c. REGISTRAR'S SIGNATURE</b> _____	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02854 CERTIFICATE OF DEATH 02829									
1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> c. LENGTH OF STAY IN 1b <b>Life Time</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> d. STREET ADDRESS <b>19-1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Robert Taylor</b>					4. DATE OF DEATH Month <b>2</b> Day <b>25</b> Year <b>1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/5/1885</b>		9. AGE (In years last birthday) Months Days <b>85 81</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Lloyd Taylor</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Morrie</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Bessie Hutt, Princess Anne, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>5020</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio Vascular Disease &amp; Hypertension</b> (c) <b>Chronic Bronchitis &amp; emphysema</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>6 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>55</b> to <b>Feb</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Feb 24</b> 19 <b>66</b> , and that death occurred at <b>11:30</b> M., from the causes and on the date stated above.									
22a. SIGNATURE <b>B. Frank Giganti</b>						22b. DATE SIGNED <b>2/28/66</b>		22c. PHYSICIAN'S NAME (Type) <b>B. FRANK GIGANTI</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/1/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>		23d. LOCATION (City, town or county) (State) <b>Princess Anne, Maryland</b>			
24. FUNERAL DIRECTOR <b>William H. James Jr. Princess Anne, Md</b>						25a. REC'D BY REGISTRAR <b>MAR 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 115ME  
SM 1/63

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02855

02830

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN Tb <b>Adult life</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		d. STREET ADDRESS <b>18 Potomac St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>18 Potomac St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN WILTON WHITNEY</b>				4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24, 1897</b>		9. AGE (in years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Rhodes Point, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Whitney</b>				14. MOTHER'S MAIDEN NAME <b>Annie Charnick</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO. <b>171-24-6123</b>		17. INFORMANT Address <b>Mrs. Cathryn Whitney, Same as 2. abcd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH Minutes <b></b> Years <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>C. G. Rawley</b>		EXAMINER'S NAME (Type) <b>C. G. Rawley, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>2/19/66</b> <b>Crisfield, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 19, 1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>American Legion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>				24a. REC'D BY REGISTRAR <b>FEB 21 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

